



OFFICE USE ONLY

☐ Approved
☐ Denied

Date

Uniform Stamp: Designation of Yellow Fever Vaccine Center

Name (last) (first) (middle initial)			CA Medical License Number (Physicians Only)	
Employer Name (if not-self employed)				
Current Address		City		ZIP code
Day Time Phone Number	Other Phone Number		Fax	
Email Address				
<i>I would like to request that the following address be added as a designated Yellow Fever Vaccine Center</i>				
1	Designated Provider (last) (first)		Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	
	Company Name			
	Center Address		City	County ZIP code
	Day Time Phone Number	Other Phone Number		Fax
	Email Address		I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO	
2	Designated Provider (last) (first)		Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	
	Company Name			
	Center Address		City	County ZIP code
	Day Time Phone Number	Other Phone Number		Fax
	Email Address		I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO	
3	Designated Provider (last) (first)		Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	
	Company Name			
	Center Address		City	County ZIP code
	Day Time Phone Number	Other Phone Number		Fax
	Email Address		I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO	
Physician Signature		Date		

You may attach additional sheets as needed